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	295085	A. BUILDING _____ B. WING _____	C 01/21/2009

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the complaint investigation conducted at your facility on 1/13/09 and completed on 1/21/09. Complaint #NV00020422 was substantiated. See F225. Complaint #NV00020505 was substantiated. See F309. Complaint #NV00020544 was substantiated. See F225. Complaint #NV00020564 was substantiated with no deficiency cited. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:
Based on record review, policy and procedure review, and interview, the facility failed to investigate and report two incidents of resident altercations to the State agency for 2 of 6 residents. (#1 and #5).

Findings include:

Resident #1 was admitted to the facility on 1/1/06 with diagnoses that included senile dementia, dementia with behaviors, and anxiety. Resident #1 lived in the special care unit (SCU), a secured wing for residents with dementia and Alzheimer's

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disease.

Review of Resident #1's medical record revealed that on 1/7/09, the following entry was documented, "Heard residents roommate yelling at roommate and CNA (certified nursing assistant) went to see what was wrong and witnessed resident punching roommate in stomach."

Resident #5 was admitted to the facility on 6/21/07 with diagnoses that included dementia with behaviors, depression, presenile dementia with delusions, and anxiety. Resident #5 lived in the SCU.

Review of Resident #5's medical record revealed that on 1/3/09, she "kicked a male resident and he responded by kicking her back on her legs".

On 1/13/09, the SCU coordinator was interviewed. She stated that an event form was filled out for any type of incident, and the resident was placed on event charting. Event charting alerts the staff and Director of Nurses (DON) that an event or condition has occurred that requires observation and daily charting. She stated that she was aware of the incidents involving Residents #1 and #5, but was not aware that the incidents needed to be reported to the State agency until earlier that day. There were no investigations completed for these resident to resident altercations.

Review of the facility's policy and procedure for abuse prohibition revealed:
Procedure B1, "Facility employee or agent who becomes aware of alleged abuse or neglect of a resident should immediately report the matter to

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F 225	Continued From page 3 the facility Administrator." Procedure B2, "If the incident involves alleged abuse or neglect, the Administrator shall provide the (State Agency) with initial notice of the alleged abuse or neglect. This notification will occur by telefaxing a copy of the report of the incident to both regulatory agencies list above within 24 hours after the incident becomes known." Procedure C4, "The Administrator shall be responsible for supervising the investigation and reporting the results of the investigation to ..." On 1/13/09, the facility administrator was interviewed and stated that neither of these incidents had been reported to the State agency. She stated that an investigation was not completed for either incident. She stated she was aware of the incident involving Resident #1. She stated it was not reported as the residents were separated, diverted into other activities, and there was no injury. The administrator stated that she would report both of these incidents and conduct and submit investigations.	F 225		
F 309 SS=G	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, policy and procedure review, and interview, the facility failed to provide the necessary care for 1 of 6 residents. (#6).	F 309		

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Findings include:

Resident #6 was admitted to the facility on 7/10/07 with diagnoses that included senile dementia, diabetes, chronic airway obstructive disease, and arthritis.

Record review revealed:

On 12/25/08, Resident #6 was complaining of her legs aching, and the certified nursing assistant (CNA) reported that the resident's legs were weak when getting up to the wheelchair. She was medicated with Vicodin 5/500 milligrams (mg) for pain three times on 12/25/08, at 11:00 AM, 7:00 PM, and 10:30 PM. Record review failed to reveal a nursing assessment of her legs or knees.

On 12/26/08, at 1:56 AM, Resident #6 complained of right knee pain. The right knee was noted to be "somewhat larger than" the left knee. The night nurse faxed an order to the physician requesting increased pain medication for severe pain episodes. The resident was placed on event charting. Event charting alerts the staff and Director of Nurses (DON) that an event or condition has occurred that requires observation and daily charting. An order was received for Vicodin 5/500 mg two tablets every four hours as needed. At 1:56 PM, the day nurse noted the right knee was swollen and painful. The nurse faxed a request to the physician for x-rays. The resident was medicated once with Vicodin 5/500 mg and once with Tylenol 1000 mg for knee pain on 12/26/08. Record review failed to reveal a response from the physician on 12/26/08 to the request for x-rays.

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On 12/27/08, Resident #6 continued to complain of pain in her knee and was medicated with Vicodin 5/500 mg one time. The physician faxed back a response to the request for x-rays asking whether there was a history of trauma, gout, or knee surgery. The return fax from the physician, was dated 12/27/08, with the time noted as 12:52 PM, approximately 23 hours after the nurse noted the request was faxed. The night nurse faxed the answers to the questions regarding the history of trauma, gout, or surgery, on 12/28/08, at 2:00 AM, 13 hours after receiving the fax with the physician's questions.

On 12/28/08, Resident #6 complained of right knee pain and was medicated twice with Vicodin 5/500 mg. The day nurse noted that the resident was on event charting for right swollen knee and noted swelling to the right knee, and that the resident had not requested pain medication during the day shift. A fax from the physician, dated 12/28/08, with a time of 1:25 PM, was received with an order for x-rays for the resident. The evening nurse noted at 7:19 PM, that the right knee was swollen and painful. The resident was medicated with on 12/28/08 with one Vicodin 5/500 mg twice, and with two Vicodin 5/500 mg one time. She received Tylenol 1000 mg one time for an increased temperature.

On 12/29/08, Resident #6 was noted to be restless, moaning of pain, with her right knee swollen. The advanced nurse practitioner (APN) saw the resident in the afternoon, and gave an order for the resident to have both knees x-rayed. The resident was medicated three times with two tablets of Vicodin 5/500 mg on 12/29/08, at 12:15 AM, 12:10 PM, and 6:00 PM.

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On 12/30/08, at 3:40 PM, Resident #6 was transferred to the hospital for x-rays. At 7:00 PM, the physician was notified that x-rays were positive for a distal fracture of the right femur, and the resident was transferred back to the hospital for evaluation and treatment. She returned to the facility on 12/31/08, at 12:30 AM, with a right knee immobilizer in place.

On 1/13/09, CNA #1 was interviewed. CNA #1 had taken care of Resident #6 on 12/25/08 and 12/26/08. She stated that the resident started to complain of severe pain after her husband came in on 12/25/08, and that she then notified the nurse of the pain and weakness in Resident #6's legs with transferring. CNA #1 stated, "She wasn't in tears, but you could tell she was in pain."

On 1/13/09, CNA #2 was interviewed. CNA #2 took care of Resident #6 on 12/25/08 and 12/28/08 on the afternoon shift. She stated that the resident had been in pain off and on for a long time. She stated that Resident #6 had complained about worse pain in her knees with transferring.

On 1/20/09, CNA #4 was interviewed. CNA #4 took care of Resident #6 on 12/28/08 during the day shift. CNA #4 stated that Resident #6 didn't really speak, but pointed to her right knee. CNA #4 asked her if her knee hurt, and the resident shook her head yes. She stated that she only transferred Resident #6 one time that day, from her wheelchair to the toilet. CNA #4 explained that Resident #6 was a two person assist for transfer. She stated that she didn't stand or bear weight on transfer on 12/28/08. CNA #4 stated that she reported to the nurse that Resident #6

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was complaining of pain in her knee.

On 1/13/09, CNA #3 was interviewed. CNA #3 took care of Resident #6 on 12/30/08 on the afternoon shift. She stated that the resident complained of pain off and on and that she was moaning in pain on 12/30/08, the day she received the x-rays.

On 1/13/09, the Director of Nurses (DON) was interviewed. She stated that when a resident had an order for x-rays, the nurses and the transporter worked out a time for the x-ray. She stated that there was not a portable x-ray available for the facility. She could not explain why the x-rays were requested on 12/26/08, ordered on 12/28/08, and not completed until 12/30/08. She acknowledged that Resident #6 had received medication for increased pain during that time. She stated that she thought there was some problem with the transporter during that time. The DON explained that if the transporter was not available, the facility was able to use the non-emergent ambulance transport. The DON explained the hospital required a physician signature on all test orders, that they would not perform the test without a physician signature. She thought it was possible that the original order written on 12/28/08 for x-rays for Resident #6 did not have a physician signature, and that is why the x-rays were not done at that time. Review of the physician order for x-rays dated 12/28/08, had a physician signature. She stated that the nurses were recently inserviced on notification of the physician for a change in resident condition.

On 1/20/09, licensed practical nurse #1 was interviewed. She stated that on 12/26/08, she noted Resident #6's right knee was swollen and

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she put a call into the physician "that morning". She stated that when she did not hear back from the physician, she faxed the request for x-rays to the physician. She did not receive a return fax from the physician on 12/26/08, and passed the information regarding the need for x-rays to the oncoming shift in change of shift report.

Review of the policy and procedure for "Change in a Resident's Condition" revealed that the nurse was to notify the resident's attending physician when "there is a significant change in the resident's physical, mental, or psychosocial status". The facility administrator provided the recent inservice material, and it included, "to use my assessment skills as a licensed nurse" and if at any time the nurse is unable to reach the attending physician, the nurses were instructed to contact the medical director.

Review of the facility's investigation of the injury, dated 12/31/08, revealed Resident #6 developed some knee pain and swelling with no known injury. The report revealed that Resident #6 reported twisting her leg in bed and had pain from then on.

On 1/13/09, the corporate nurse consultant was interviewed. She had no explanation as to why Resident #6 had not received x-rays sooner than 12/30/08.